DRAFT
United States Agency for International Development
Bureau for Democracy, Conflict and Humanitarian Assistance
Office of Food for Peace

Fiscal Year 2012: Questions and Answers on Health and Nutrition Programming: Title II Development Programs

1. What is the difference between a preventive and a recuperative approach to undernutrition?

The first consideration in programming is prevention. As in any public health intervention, prevention means population-based coverage. As an analogy, consider the polio vaccine: all children in a population are entitled to, and should get the polio vaccine no matter the socioeconomic status of the household. Similarly, **all** children in a population with high stunting rates (as stated in select FFP country specific information on target areas) are at risk of becoming malnourished and thus should be protected from the ravages of nutritional deficiencies. This is a key concept. Recuperation is a disease-oriented approach. To continue the polio analogy, it would be focused on the rehabilitation of those children who are infected and affected by the polio virus. From a public health perspective, it is far more cost effective to prevent than to recuperate, even though recuperation continues to be necessary.

2. How can a preventive approach be targeted in Title II development programs?

A preventive approach should first and foremost be prioritized to the most food insecure areas (i.e., districts). Country Specific Information and the Bellmon Estimation Studies for Title II (BEST) analyses identify these most food insecure areas. Linking with existing health services is a priority, whenever possible.

3. What are important programming considerations to take into account when designing a program to prevent undernutrition in children under two?

According to the UNICEF conceptual framework,[1] nutritional status is a function of three key factors: health, diet and care. Those three factors interact with one another in several ways. For example, a child who is not healthy has poor appetite, will eat less and may not be able to take advantage of the nutrients in the food s/he receives; likewise, a child who has a poor diet has less resistance to disease. "Care" is determined by whether proper practices (such as, feeding practices, health seeking behaviors, pregnancy spacing, social stimulation, etc.) are used to ensure adequate health, development and diet of the child. Deficiencies in any of those aspects will pave the way to undernutrition. What a preventive approach (focusing on the "first 1000 days") to undernutrition represents is the application of this conceptual framework to a programmatic context. Specifically, this means that the objectives of a preventive program are to offer a child access to quality in terms of health services, diet, and care practices.

[1] UNICEF. (1990). Strategy for Improved Nutrition of Children and Women in Developing Countries. New York: UNICEF

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4. **What is the purpose of blanket feeding of children under two and pregnant and lactating women in a development program that focuses on developing sustainable ways to prevent undernutrition?**

What is important in preventing undernutrition is not necessarily food aid, but a quality diet along with health services and care. If households in a given context are able to access enough high quality food to feed their child most of the time, then awardees should trust that system to do so and reserve the food distribution for the critical moments when the food is not there and/or when the households cannot afford it, such as the hungry months at the end of the dry season, or before harvests. In the environments where our applicants and awardees work, it is rare that households will be able to source enough food (and of sufficient quality) to feed their child most of the time, and usually less so at the beginning of a development program. In these cases, the purpose of blanket feeding of children under two and pregnant and lactating women is to improve dietary quality and provide important vitamins and minerals that may not be available otherwise. However, where it is possible for households to procure much of their own foods, there are some programming models that may be helpful in achieving improved quality of the diet along with improved care and feeding practices.
See: *The Essential Nutrition Actions (ENA) Framework* , *The Nutrition Program Design Assistant: A Tool for Program Planners (NPDA)* on the Coregroup website http://www.coregroup.org/our-technical-work/working-groups/nutrition
and *The Grandmother Project*. http://www.grandmotherproject.org/articles.php. Additionally, as applicants think through issues of program design, they may want to consider questions of sustainability and how participation in programs to improve nutrition of children during the first 1000 days may be maintained in the absence of food aid, along with a phased approach that might include food aid in the early stages and other types of incentives and approaches once food security is improved. It may be useful to consider the experiences of initiatives such as Care Groups
www.caregroupinfo.org/docs/FSN_Network_SBCTF_Approved_Methods_and_Tools_Aug_2011.pdf ; Pastoral da Criança: https://www.pastoraldacrianca.org.br/;
Baby Friendly Community Initiatives in countries like the Gambia: http://www.nana.gm/;
the Nicaragua Mother and Baby Friendly Health Units Initiative:
http://www.hciproject.org/sites/default/files/NicMotherBabyFriend.pdf and the Evaluation of the Title II program in Bolivia that used Integrated Attention to the Child (Atención Integral al Niño:AIN):http://pdf.usaid.gov/pdf_docs/PDACO837.pdf.

5. **What is the added value of food aid in preventing undernutrition in Title II development programs?**

The key resource that FFP has to offer, i.e. the Title II food aid commodities, can go a long way in ensuring that children have access to a quality diet in the highly food insecure situations in which our partners work. Title II food aid commodities are used in a preventive approach for nutritional purposes- improving dietary quality for young children and pregnant and lactating women and for "non-nutritional" purposes- for example, incentivizing households to continue program participation-but both purposes can help to prevent undernutrition in women and children.

6. **What is the role of current Title II commodities in responding to the nutritional needs of pregnant and lactating women and children under two?**

FFP is in the process of improving the quality and variety of food aid in response to the Food Aid Quality Report (FAQR) recommendations.

Fortified blended foods like corn-soy blend (CSB) provide many micronutrients, but the current formulation of CSB13 does not provide all of them in the right quantities, particularly for infants between 6-12 months. The main limitations are tied to iron and zinc levels. As part of the implementation of the FAQR recommendations, these limitations will be addressed; however it will take some time and research before FFP has evidence to show whether the proposed revisions to the CSB13 specifications (called CSB14) are adequate for the 6-24 month-old infants targeted for prevention of malnutrition. The WFP formulation of CSB+, now available through the Title II commodity list, offers some improvement in these two critical micronutrients, which are currently limiting in CSB13.

In thinking beyond the existence of the Title II program, applicants should consider program designs that will offer families alternatives for providing the necessary micronutrients through interventions that can diversify the diet (e.g., home gardening, small livestock raising, etc.) or through technical solutions like lipid-based nutrient supplements (LNS) (e.g., Nutributter®) or micronutrient powders (such as Sprinkles®) sachets of micronutrient powders that are used like a condiment on the child's food).

7. **How might negative incentives of food aid rations to women of reproductive age (i. e., those who may become pregnant to receive a food aid ration) be addressed within the context of a blanket feeding program? Will mothers who become pregnant while receiving rations for another child become ineligible for FFP funded preventive nutrition and health activities?**

There is no evidence to indicate that providing preventive nutrition and health services, including food aid rations, to all pregnant females has a pro-natal effect. FFP would not recommend that any pregnant woman be denied participation in a program activity because she will have/has another child while participating in the activity. In addition, most likely Ministries of Health would not allow the provision of services to some pregnant women in the public health system and not to others. Individual development programs address these potential challenges through the educational component that addresses healthy pregnancy spacing, by working with partners to strengthen family planning services as well as by facilitating access to family planning services available in the food aid program area.

8. **Is FFP open to programs offering food aid rations to the target groups (pregnant and lactating women and children 6-23 months) while also promoting locally produced weaning and other nutritious food until the child reaches two years of age?**

Yes, FFP encourages the use of home-based, locally produced weaning foods after six months of age. Through the behavior change communication component of preventive health and nutrition

programs, development programs should be promoting locally available nutritious food for infants and young children and pregnant and lactating women that can be combined with the food aid ration, and children should be introduced to a range of diverse foods. However, in terms of the quality of the diet, it is important to note that breastfed infants and young children between 6-24 months only need small amounts of food to meet their total energy needs. So foods provided to children should be very nutrient-dense, including rich in both macro- and micro-nutrients. Local diets, **as well as food aid commodities**, can do a good job at providing the macro nutrients (i.e., carbohydrates, proteins, lipids, etc.). However, local diets, unless they are fortified and sufficiently nutrient dense, may not do a good job at providing the micro-nutrients (i.e., vitamins, minerals) that are so critical to a child's growth.

9. **Is there a minimum package related to strengthening of antenatal, post-partum, integrated care of the child and family planning services that should be included in proposals?**

Applicants should determine what the country policy is for maternal and child health and nutrition services, what types of health service strengthening may be occurring and what efforts need to be supported, coordinated and/or facilitated in the areas they propose to cover, taking into account national efforts, bilateral and other efforts, family planning and GHI activities aimed at strengthening these services. There is guidance on a minimum package of health services, which include antenatal care, post-partum care, micronutrient supplementation, immunization and treatment of childhood illness, as described in the host country Ministry of Health's policies and protocols. For this guidance, applicants can refer to Knowledge for Health e-toolkits website: http://www.k4health.org/Toolkits/topics and technical reference materials at the MChip website: http://www.mchipngo.net/controllers/link.cfc?method=tools_tech. They may also refer to the Prevention of Malnutrition in Under Twos Approach (PM2A) Technical Reference Materials (TRM) at the following websites: http://www.usaid.gov/our_work/humanitarian_assistance/ffp/fy10_pm2a.ver1.pdf and http://www.fantaproject.org/pm2a/index.shtml.

Many geographic areas will have limited, inconsistent or no access to these services. In these situations, applicants should describe the weaknesses in the services provided in their proposed geographic areas and suggest ways to work to make essential health and nutrition services available and accessible in order to protect the health and well-being of mothers and children.

For additional references on integrating health and family planning service strengthening into a proposed program, see: Integrating Family Planning and Maternal and Child Health Care: Saving Lives, Money, and Time (Population Reference Bureau): http://www.prb.org/pdf11/familyplanning-maternal-child-health.pdf

10. **Will direct distribution as a result of blanket food aid rations create a disincentive for production? With only the Haiti study to use as a "standard," there are concerns about overuse of food resources and potential unintended consequences to the local economy because of the food aid rations.**

The BEST analyses recommend levels of blanket distribution that are calculated to avoid creating a disincentive for production or any unintended consequences.

11. Are applicants expected to use ration sizes from the Haiti PM2A study in other locations? Can more guidance be given on how to develop the mother and child's ration?

Applicants have flexibility to propose the ration composition and size that is appropriate for the target groups. The PM2A Technical Reference Materials (TRM) contains guidance on ration design and targeting as well as exit strategies and sustainability.

12. Are applicants expected to create an incentive size household ration (targeting the foods to precisely the same vulnerable groups as in the pilot PM2A studies)?

The purpose of the household ration is to supplement the household food supply, when necessary, prevent sharing, and/or incentivize participation. Applicants should describe and justify the assumptions used to determine the ration, monitor the ability of the ration to achieve these objectives and ensure that any modifications to ration size are not affecting critical outcomes, and to contribute to the body of experience and evidence on ration use in development programming. Applicants should keep in mind that in most cases, the purpose of the household ration is not to improve nutritional status of the household and commodity selection should reflect the actual purpose. In addition, to prevent sharing, applicants may want to consider if a household ration with different commodities than the individual rations for young children and pregnant and lactating women would be most appropriate in the given context.

In relationship to household rations, applicants should consider the following two points when either requesting a particular type and size of ration to ensure participation in the program and/or providing justification for any requested household ration(s):

(1) The first point is concerned with the intended use of the food in the program design. The primary aim of the individual rations in a prevention of chronic malnutrition feeding strategy for mothers and children under two is to ensure that the biological needs of the child and the pregnant/lactating mother are met. These individual rations are not large; they should aim to cover the extra energy requirements in pregnancy and lactation, and meet a certain portion of the energy needed from complementary foods for the child, depending on the particular context and level of food insecurity. However, if food insecurity is great, the household ration needed to ensure that the biological needs are met through the individual rations may represent the largest portion of the food donated to households. The aim of the household ration is not "biological," it is used to fill a gap in the household food supply, prevent sharing, as an incentive or all three. Filling the gap in the household food supply may also have an indirect effect on the child's nutrition because there is more food available within the household, perhaps providing the mother with more time to care for the child.

(2) The second point relates to the incentive function of the ration. This function is to ensure continued participation of mothers/caregivers in the preventive program through various

types of activities such as behavior change sessions, clinic visits, growth monitoring, etc. Food aid commodities act as a conditional transfer. If the mother goes to the health clinic, attends the education sessions, brings her infant in for growth monitoring and immunization and participates in other preventive activities, the mother would receive an incentive ration in addition to the individual biological rations which may be necessary for pregnant and lactating mothers and infants and young children between 6-23 months and there would be no other type of household ration. The effect of the household ration on the child is again indirect because the use of conditional transfers should increase attendance to Behavioral Change Communication (BCC) sessions and to clinic visits thus providing the elements needed to complete UNICEF's "virtuous nutrition circle". But since the food plays no direct role in ensuring the biological needs of the child, the question here is not how much food is needed to feed the household, **but how much food is enough to guarantee participation**? The answer may vary widely but should be **as little as possible to guarantee continued participation in the program**. Currently, part of the FANTA-2/International Food Policy Research Institute (IFPRI) operations research in pilot prevention of chronic under-nutrition programs is directed toward trying to answer that particular question, but this will always be contextual as well as seasonal.

13. What is the balance between ration size and total beneficiaries served? Country specific information recommends coverage of large geographic areas, which are not coverable with finite resources; how should geographic coverage be chosen?

Applicants may choose to cover all or just some of the geographic priority areas identified in the country specific information. Targeting within priority geographic areas should be done based on assessment and indicators of relative food insecurity.

14. How should applicants treat moderate malnutrition within the context of a preventive program? Specifically for children 6-23 months of age, how are the moderately malnourished served and how does this differ from children 24-59 months of age?

Applicants may propose approaches to treating moderate malnutrition among the target population of those under two and among older children, as well as define objectives and indicators to measure the impact of recuperative interventions. However, resources are finite, so applicants should carefully consider what activities will not be done if they are to focus on recuperation. Note that underweight may be caused largely by stunting in older children in some countries, and provision of a short-term ration for recuperation may simply cause already stunted children to gain body weight but not height.

15. To what extent should applicants ensure treatment and/or nutritional support of children targeted for Severe Acute Malnutrition (SAM), as well as Moderate Acute Malnutrition (MAM) at health center (outpatient) and Center for Nutritional Rehabilitation (CREN) (in-patient) levels?

Title II-supported programs aim to reduce the prevalence of chronic malnutrition and underweight in children. Preventive health and nutrition approaches are recommended because

they aim to prevent and reduce malnutrition in young children who are often at the highest risk of stunting and acute malnutrition. When pregnant and lactating women and young children 6-23 months of age are provided supplemental food under preventive programs, reductions in acute malnutrition prevalence are expected, but some acute malnutrition will likely still occur. The preventive approach also includes screening and referral for children with SAM and home visits to follow young children with SAM. Applicants are encouraged to coordinate and collaborate with the health system, other nongovernmental organizations and community based organizations to ensure screening, referral and treatment for children with acute malnutrition.

16. Will the Title II development programs directly fund the care of acute malnutrition?

A preventive program, which focuses on improved health, nutrition and care practices, should contribute to decreasing the incidence of acute malnutrition through improvements in health preventive practices such as immunization, deworming, malaria prevention and treatment, community integrated management of childhood diseases (c-IMCI), growth promotion and monitoring and improved pregnancy spacing.

The treatment of severe acute malnutrition (SAM) should be part of health systems strengthening. Rather than treating SAM directly, Title II partners should work with health partners to strengthen the capacity of the health services to treat SAM.

In terms of the care of severe acute malnutrition, note that FFP policy does allow, at this time, the purchase of ready to use therapeutic foods (RUTFs) with Title II funds (specifically, either with section 202(e) funds with certain conditions or with cash proceeds from monetization). Ties to health systems are critically important to provide inpatient services that link with and complement the outpatient and community outreach component provided by awardees. If the prevalence of acute malnutrition is high enough that it is a significant problem in the food aid program area, then the applicant should develop a separate intermediate result that focuses on those activities.

RUTFs may also be purchased from section 202(e) funds for "new" development programs and for emergency programs under these conditions as spelled out in FFPIB 11-01:

- An emergency program within a development program that targets a distinct area or population not served by the same organization under a pre-existing Title II program may be considered as "new" for the life of the award (LOA). The term "new" does not apply to subsequent food aid programs or modifications that simply broaden the existing food aid program area or target population;
- An on-going emergency program that is undergoing a re-design in order to introduce multi-year development interventions may be considered as "new" for the LOA;
- A development program that targets a distinct area or population not served by the same awardee under a pre-existing food aid program may be considered as "new" for the LOA; and
- A development program that follows a single-year emergency program in the same area or that targets some or all of the same population may be considered as "new" for the LOA.

If not fulfilling these conditions, RUTFs may be purchased with monetization funds.

17. As Guatemala and Burundi research programs produce evidence, will there be assumptions that current development programs need to incorporate them? Will awardees be expected to change the approved preventive activities based on research results from PM2A activities implemented in food aid programs in other countries?

FFP will not require existing food aid programs to change implementation design based on research results. Awardees may choose to adjust designs, within Life of Agreement (LOA) levels, if the research suggests cost-effective improvements.

18. What resources will be available (beyond the Burundi and Guatemala studies) for applicant research? How are awardees expected to pay for research?

Applicants should include the resources required for program quality assurance, quality improvement and monitoring and evaluation. There will be no external research component for additional countries at this time.

19. Are there plans to update the Commodity Reference Guide to reflect guidance for ration design?

The *Commodity Reference Guide* will be revised and updated based on both FAQR recommendations as well as other ongoing studies. It will not be finalized before fiscal year 2012 applications are due. Where there are contradictions between the RFA and the current *Commodity Reference Guide*, applicants should follow the RFA, as it is more up-to-date.

20. What indicators will be used to measure success of nutrition activities?

Monitoring and Evaluation (M&E) requirements, including required FFP indicators, are described in the *Title II Guidance* and in the most recent Food for Peace Information Bulletin on indicators and reporting. In addition to the relevant required FFP and USAID/Mission indicators, applicants should identify proposed program indicators in the indicator performance tracking table (IPTT) and describe methods that will be used to collect them.

21. How will nutrition programming success be measured globally?

The standardized annual performance questionnaire (SAPQ) submitted with the annual results reports has been designed to facilitate aggregation across development programs. However when awardees do not submit the SAPQ fully and correctly, this limits FFP's ability to measure global success of the Title II programs.

22. How do applicants prevent double counting and confounding factors in monitoring?

Applicants must propose and implement a monitoring and evaluation system that provides the information needed to adequately monitor food aid program implementation and report on progress and achievements.

23. How do development proposals ascertain that other administrative programs are accountable for regional results?

Performance indicators selected for inclusion in the IPTT should measure changes that are clearly and reasonably attributable, at least in part, to the development program. In the context of performance indicators and reporting, attribution exists when the outputs of the program have a logical and causal effect on the result(s) being measured by a given performance indicator. If more than one agency or government is involved in achieving a result, awardees should describe what role each played in achieving the result.

24. For the review process, what is the balance between the quality of programming and target group coverage?

Quality of programming is paramount to achievement of results. Applicants should propose coverage that allows good quality programming to be implemented, and explain reasoning and assumptions in the proposal narrative. Where possible, applicants should describe how they will interact with other USG initiatives such as FtF and GHI in order to improve the quality of programming and the possibility of scaling up or out.

25. How can applicants learn more about Behavior Change Models?

There are a number of Behavioral Change Communication (BCC) and Behavior Change models information products (e.g., guides), methods, and tools (IMT) that are available as resources.

1. **Barrier Analysis:**
   - **Barrier Analysis Manual:** http://www.coregroup.org/storage/Tools/Barrier_Analysis_2010.pdf

2. **Care Groups:**
   - **Care Group Manual:** http://www.k4health.org/system%252Ffiles%252FCare%2BGroup%2BManual.pdf and a number of resources on Care Groups on: http://www.caregroupinfo.org/blog/narrated-presentations-on-care-groups-and-care-group-tools

3. **Designing for Behavior Change Curriculum (2008):** http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

4. **Partnership Defined Quality manual: PDQ Facilitator's Guide** http://www.coregroup.org/storage/documents/Diffusion_of_Innovation/Save_PDQ_Facil_Guide.pdf

5. **PD/Hearth Manual:**
   - **PD/Hearth Manuals (English, Spanish, French, Portuguese, Indonesian) and other materials:** http://www.coregroup.org/our-technical-work/initiatives/diffusion-of-innovations/84

For Trials of Improved Practices (TIPS) see:
http://www.manoffgroup.com/approach_developing.html

For up-to-date information and links to resources related to "1000 days", see
http://www.thousanddays.org/ and http://www.thousanddays.org/resources/

For reference materials on Feed the Future, see
http://www.feedthefuture.gov/

For reference materials related to Global Health Initiative, see: http://www.ghi.gov/